UTAH DIABETES SELF-MANAGEMENT EDUCATION

A Toolkit For Understanding Evidence-Based Diabetes Self-Management Education (DSME) Programs

UTAH DEPARTMENT OF HEALTH
Healthy Living Through Environment Policy and Improved Clinical Care (EPICC)

TOOLKIT CONTENTS

PURPOSE OF GUIDE

Diabetes is a chronic disease that requires a person to make a multitude of daily self-management decisions and perform complex care activities. Diabetes Self-Management Education (DSME) provides an evidence-based foundation to help people with diabetes navigate these decisions and activities, and has been shown to improve health outcomes.[1]

The purpose of this toolkit is to provide guidance and understanding of DSME programs to healthcare professionals interested in becoming a DSME provider. The toolkit is designed to help healthcare professionals understand the requirements for establishing a DSME program that meets minimum standards and is eligible for reimbursement. The toolkit will review program definitions and national standards for diabetes education, implementation processes, eligibility and reimbursement, and provide application resources for becoming an accredited DSME provider.

*Note: Diabetes Self-Management Training (DSMT) is a term used by the Centers for Medicaid and Medicare Services (CMS) for determining coverage and reimbursement of DSME and completing documentation. Diabetes Self-Management Training (DSMT) is often used interchangeably with Diabetes Self-Management Education (DSME) and may be referred to as DSME/T. For this purpose, DSME will be referred to as DSME/T throughout the remainder of the toolkit.

DSME = DSMT

IMPACT OF DIABETES[2]

Diabetes is a serious public health concern in the U.S. According to the U.S. Centers for Disease Control and Prevention:

- Approximately 30.3 million Americans (9.4% of the population) have diabetes, an increase from 29.1 million in 2012.
- Diabetes is the 7th leading cause of death in the U.S. and Utah.
- Of the 30.3 million people with diabetes, approximately 23.1 million are diagnosed and 7.2 million are undiagnosed.
- An estimated 1.5 million Americans are diagnosed with diabetes each year.
- Along with diabetes come risks for several complications and comorbid conditions such as hypertension, dyslipidemia, kidney disease, cardiovascular disease, and amputations.
- The total direct and indirect estimated cost of diagnosed diabetes in the U.S. in 2012 was $245 billion.
- The average medical expenditure among people with diagnosed diabetes is 2.3 times higher than those without diabetes.

Fortunately, individuals with diabetes can improve their quality of life through mindful lifestyle choices and by learning effective techniques for managing the disease. Risk of complications and comorbid conditions related to diabetes can be significantly reduced through proper control and management.

Effective control and management of diabetes is achieved through a collaborative work between Diabetes Self-Management Education (DSME/T) and clinical preventive services involving the patient and his or her healthcare provider.

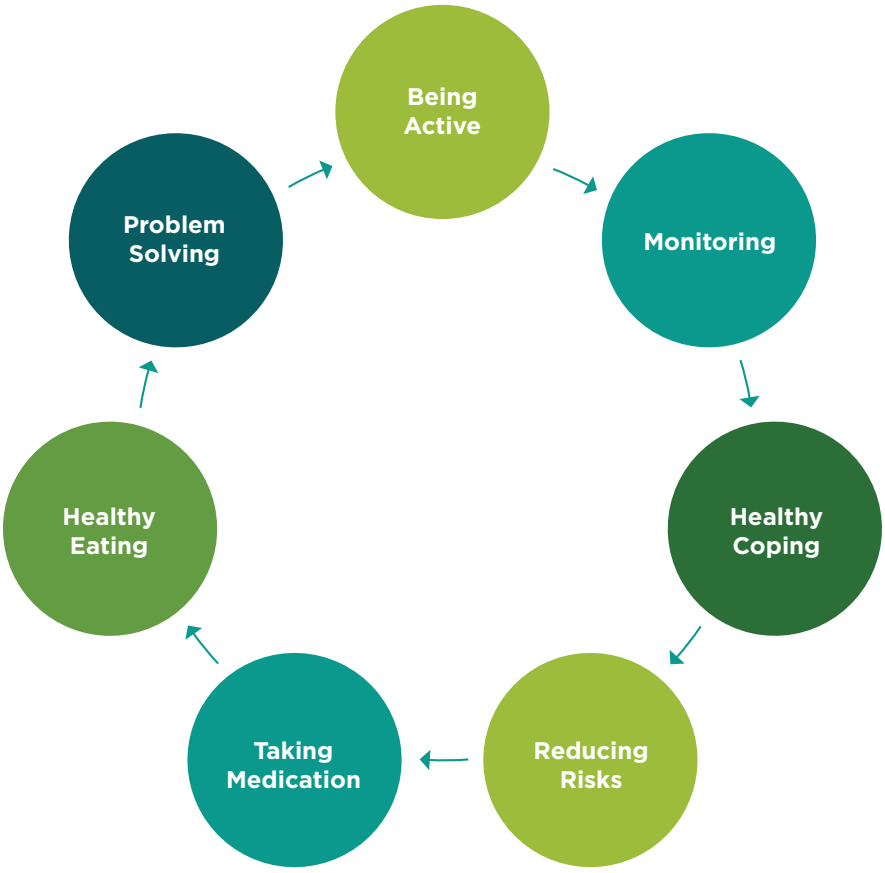
DIABETES SELF-MANAGEMENT EDUCATION

Diabetes Self-Management Education (DSME/T) is the active, ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care.1 Guided by evidence-based standards, this process incorporates the needs, goals, and life experiences of the person with diabetes into a collaborative plan for managing diabetes and preventing complications. The process changes and adapts as a person's needs, priorities, and situations change. The overall objectives of DSME/T are to support informed decision-making; improve self-care behaviors; encourage effective problem-solving and active collaboration with the healthcare team; and to improve clinical outcomes, health status, and quality of life.[1,3]

DSME/T programs are educational programs taught by skilled health professionals in group settings, one-on-one, or via telehealth. DSME/T classes are most often held at a hospital, clinic, pharmacy, or community setting. Diabetes educators utilize DSME/T curricula to educate and engage participants in informed decision-making, reinforce self-care, and teach problem-solving and collaborative behaviors with their healthcare providers to improve clinical outcomes.

DSME/T is based on the American Association of Diabetes Educators (AADE) developed seven self-care behaviors (AADE7). The AADE7 compose the core of all DSME/T programs and provide guidance for focus areas that will be targeted in patients with diabetes to help them navigate a personalized plan and maximize health.5 The AADE7 are widely recognized as the guiding principles for participants in a DSME/T program.

For detailed information on each self-care behavior, visit the AADE7 Self-Care Behavior resource at https://www.diabeteseducator.org/patient-resources/aade7-self-care-behaviors.



PATIENT BENEFITS

Less than 60 percent of patients with diabetes receive diabetes education.[2] Patients who receive DSME/T:[3,4]

- Have improved hemoglobin A1C levels.
- Have better control of blood glucose and are more likely to self-monitor as prescribed.
- Are more likely to use primary care and prevention services.
- Have higher rates of medication adherence.
- Have better control of blood pressure and cholesterol levels.
- Have lower overall health costs.
- Have fewer complications related to their diabetes.
- Are more likely to adopt healthy lifestyle behaviors, such as good nutrition and physical activity.
- Understand how to prevent, detect, and treat hyper/hypoglycemia.
- Develop strategies for promoting healthy behaviors and positive lifestyles.

BENEFITS OF BEING A DSME/T PROVIDER

In addition to the impactful ways in which DSME/T can improve disease management for the patient, the following are benefits of being a DSME/T provider:[3]

- DSME/T is a billable service through Medicare, Medicaid, and most private insurers if provided by an accredited or recognized program.
- May help providers/clinicians meet quality improvement goals and improve population health.
- Improved patient health status reporting.
- Cost-effective by reducing hospital admissions and readmissions.
- Improved clinic/care flow capacity with less recurring visits.

HOW DSME/T IS PROVIDED

DSME/T is a team-based approach, where clinicians and educators work together to promote the best possible health outcomes for patients. Diabetes educators are licensed healthcare professionals including physicians, pharmacists, registered nurses, and registered dietitians, and may be found in a variety of settings such as pharmacies, hospitals, clinics, or community locations.[6]

All DSME/T programs are required to have designated, qualified healthcare professionals to provide DSME/T classes. The minimum requirements for accredited DSME/T program personnel include:

PHARMACY	ALL OTHER SETTINGS
Pharmacist	**Physician** (for billing purposes only)
Registered Dietitian (RD) (only if providing Medical Nutrition Therapy (MNT))	**Registered Dietitian (RD)** AND/OR **Registered Nurse (RN)**

In addition to certified DSME/T providers, **Community Health Workers (CHWs)** may also play an important and beneficial role in bridging gaps and needs for DSME/T efforts. CHWs have a unique ability to serve as "bridges" between community members and healthcare services and provide additional benefits such as:[7]

- **Increasing participation** in DSME/T by acting as a referral partner for DSME/T providers.
- **Overcoming language barriers** for maximum understanding and communication.
- **Meeting cultural and traditional needs** to achieve positive health outcomes.
- **Improving time management** and program efficiency by providing basic diabetes education.
- **Facilitating transportation** to services and addressing other barriers to services.

MULTI-LEVEL TEAM-BASED APPROACH

Although not required for certification through the American Association of Diabetes Educators (AADE) or the American Diabetes Association (ADA), it is highly recommended that at least one of the DSME/T team providers be a Certified Diabetes Educator (CDE). CDEs are licensed healthcare professionals – registered nurses, registered dietitians, and pharmacists, among others – who have specialized training in helping people with diabetes learn how to manage their condition. For more information on becoming a CDE visit the National Certification Board for Diabetes Educators website at http://www.ncbde.org/.

The following provides a broad example of how a multi-level healthcare team may be constructed to provide a DSME/T program in a clinic, hospital, or pharmacy setting. Please note that personnel and roles will vary depending on the organizational structure of the DSME/T program.

STAFF	DSME/T ROLE
Physician, Pharmacist, or Mid-Level Provider	• Make referrals to DSME/T • Prescribe medication • Order laboratory tests • Diagnose disease • Coordinate diabetes education/clinic/research • Teach DSME/T classes
RN or RD	• Provide 1:1 education • Teach DSME/T classes • Conduct assessments
LPN or MA	• Initiate referral to DSME/T • Obtain vital measurements • Conduct meter training • Perform lab tests
Social Worker	• Connect patient with additional resources needed • Assist with coping mechanisms and social needs
CHW	• Review self-care steps • Initiate referral to DSME/T • Reinforce appropriate physical activity and nutrition

REFERRAL PROCESS FOR DSME/T

In order for a patient to receive DSME/T coverage, and for the DSME/T program to be eligible for reimbursement, a referral from a physician or mid-level provider must be made.

As a provider of DSME/T services, you are responsible for:

- Promoting your DSME/T program and classes in your area.
- Developing your own process for receiving and processing referrals from other providers.
- Creating an internal process for identifying patients you serve to refer to your DSME/T program.

Generally, DSME/T providers are most successful in the referral and registration process when roles and responsibilities of the healthcare team are clear. For example, consider designating one team member as the referral processor for all incoming DSME/T program referrals.

IDEAS FOR OBTAINING REFERRALS

- Promote your program to local health clinics and hospitals which are not providing DSME/T.
- Market your program to individual providers who treat patients with diabetes and provide resources for referring (e.g. link to referral form, explanation of referral process).
- Offer classes at varying times such as evening, weekends, or a day-long program.
- Promote your program by creating a website, brochures, handout materials, quarterly newsletters, or by utilizing social media.
- Foster relationships with employers with worksite wellness programs.
- Create an engaging program for patients and become recognized in the community.

The DSME/T and Medical Nutrition Therapy (MNT) Services Order/Referral Form at the end of this guide is one example of a referral material you may use. For additional information on referrals, visit https://www.diabeteseducator.org/practice/provider-resources/make-a-referral.

CRITICAL TIMES TO PROVIDE DSME/T[4]

There are four identified critical times to assess, provide, and adjust DSME/T.

1. With a new **diagnosis** of diabetes.
2. **Annually** for health maintenance and prevention of complications.
3. When new **complicating factors** influence self-management.
4. When **transitions** in care occur.

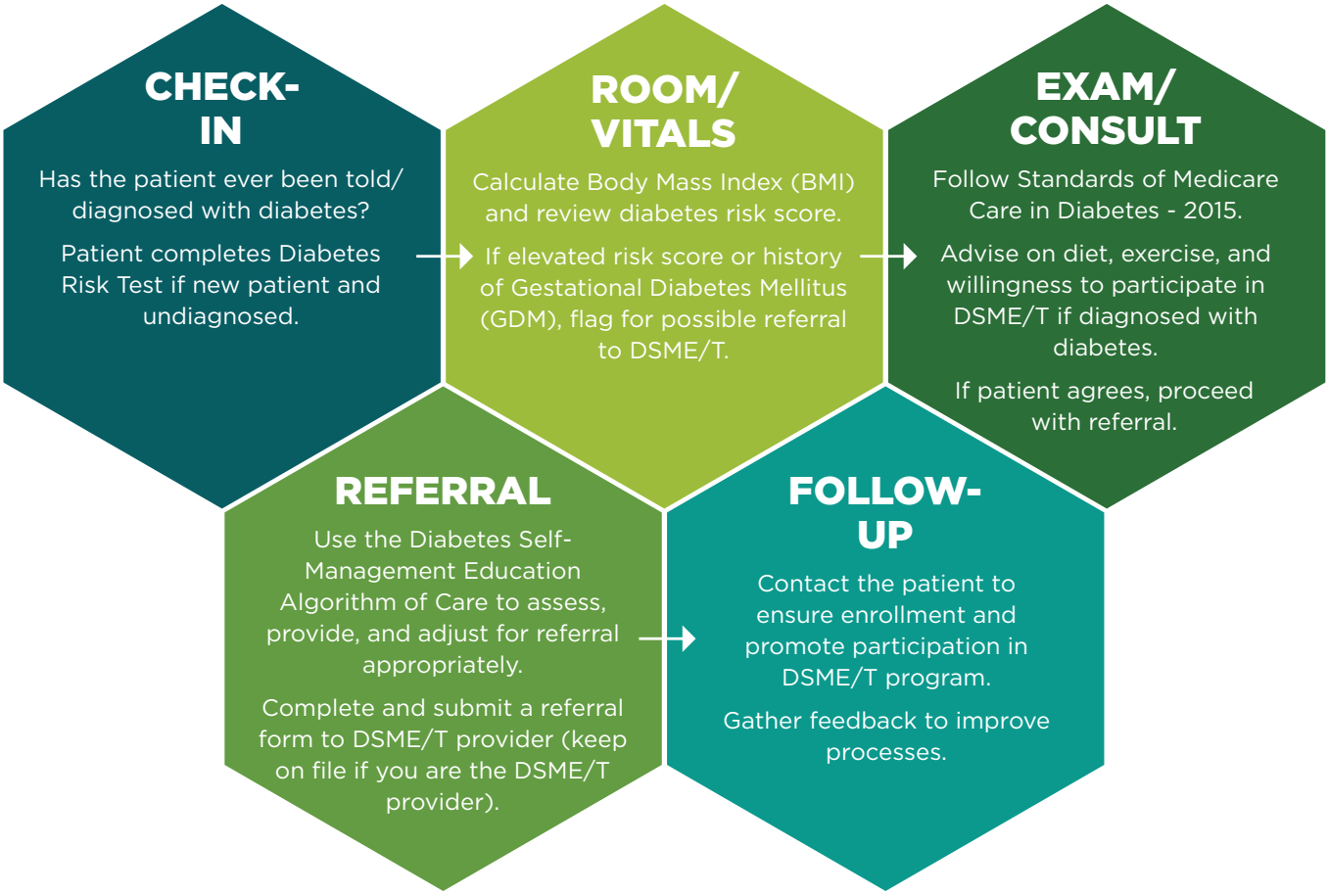
Below are the action steps for the Algorithm of Care for DSME/T. For the complete guidance chart and Joint Position Toolkit, visit https://www.diabeteseducator.org/practice/educator-tools/joint-position-statement-toolkit.

DSME/T ALGORITHM OF CARE

Nutrition Registered Dietitian for Medical Nutrition Therapy	**Education** Diabetes Self-Management Education and Support	**Emotional Health** Mental Health Professional, if needed

Four Critical Times to Assess, Provide, and Adjust DSME/T			
1 **At Diagnosis**	**2** **Annual** assessment of education, nutrition, and emotional needs	**3** When new **complication factors** influence self-management	**4** When **transitions** in care occur
When Referral to DSME/T Should be Considered			
• Newly diagnosed. All newly diagnosed individuals with diabetes should receive DSME/T. • Ensure that both nutritional and emotional health are appropriately addressed in education or make separate referrals.	• Needs review of knowledge, skills, and behaviors. • Long-standing diabetes with limited prior education. • Change in medication, activity, or nutritional intake. • HbA1c out of target. • Maintain positive health outcomes. • Unexplained hypo/hyperglycemia. • Planning pregnancy or currently pregnant. • For support to attain and sustain behavior change(s). • Weight or other nutrition concerns. • New life situations and competing demands.	Change In: • Health conditions such as renal disease and stroke, need for steroid, or complicated medication regimen. • Physical limitations such as visual impairment, dexterity issues, or movement restrictions. • Emotional factors such as anxiety or clinical depression. • Basic living needs such as access to food, or financial limitations.	Change In: • Living situation such as inpatient or outpatient rehabilitation or now living alone. • Medical care team changes. • Insurance coverage that results in treatment change. • Age-related changes affecting cognition, self-care, etc.
DSME/T: Areas of Focus and Action Steps			
Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, and literacy to determine content to provide: • Medications-choices, action, dosing and titration, and side effects. • Monitoring Blood Glucose (BG)-when to test, interpreting and using glucose pattern management for feedback. • Physical Activity-safety, short vs. long term goals, recommendations. • Complication prevention, detection, and treatment. • Nutrition-food and meal planning, purchasing food, proportioning food. • Risk Reduction-smoking cessation, foot care, dental care, skin care, eye exams.	• Review and reinforce treatment goals and self-management needs. • Emphasize preventing complications and promoting quality of life. • Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands. • Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes.	• Provide support for the provision of self-care skills in an effort to delay progression of the disease and prevent new complications. • Provide/refer for emotional support for diabetes-related distress and depression. • Develop and support personal strategies for behavior change and healthy coping. • Develop personal strategies to accommodate sensory or physical limitation(s), adapting to new self-management demands, and promoting health and behavior change.	• Identify needed adaptions in diabetes self-management. • Provide support for independent self-management skills and self-efficacy. • Identify level of significant other involvement and facilitate education and support. • Assist with facing challenges affecting usual level of activity, ability to function, health beliefs, and feeling of well-being. • Maximize quality of life and emotional support for the patient. • Provide education for others now involved in care. • Establish communication and follow-up plans with the provider, family, and others involved.

EXAMPLE PATIENT FLOW PROCESS[4]



IMPORTANCE OF FOLLOW-UP[7]

Typically, once a patient receives a diagnosis of diabetes, a provider will speak to the patient about the importance of self-care and direct them to complete critical self-management behaviors such as taking medication, monitoring blood glucose, completing regular physical activity, consuming a healthy diet, and losing weight if necessary. However, research shows that without active follow up and reinforcement, patients are likely to experience challenges to following their healthcare provider's advice.

- Medication – only 77% of patients with diabetes take insulin as prescribed while 85% take other medications as prescribed.
- Monitoring – fewer than half (45%) of patients monitor their blood glucose as instructed by their healthcare provider.
- Exercise and Weight Loss – only 24-27% of patients closely follow the instructions from their healthcare provider.

The follow-up for DSME/T may be just as important as the diagnosis and referral itself. By incorporating reminders, follow-up procedures, and reinforcement into office procedures and daily tasks, clinicians and DSME/T providers may greatly increase the likelihood that patients will successfully enroll and participate in DSME/T program and increase their ability to improve their knowledge and skill to manage their disease.

Reimbursement for DSME/T provided by a recognized/accredited program is available from the Centers for Medicare and Medicaid Services (CMS) and many private payers.

Please Note: Although DSME/T is the preferred term, for the purpose of reimbursement and documentation, CMS requires using the term Diabetes Self-Management Training (DSMT).

In order to be eligible for DSME/T reimbursement, DSME/T programs must be recognized or accredited by a CMS designated National Accreditation Organization (NAO).[3] The two current NAOs are the American Association of Diabetes Educators (AADE) and the American Diabetes Association (ADA).

PATIENT ELIGIBILITY

In order for a patient to qualify for DSME/T coverage, he or she must have:

1. A **diagnosis** of type 1, type 2, or gestational diabetes, **OR**
2. Been **previously diagnosed** with diabetes before meeting Medicare eligibility requirements **and are now eligible** for coverage, **AND**
3. A **written referral** from a physician or mid-level provider.

Diabetes may be diagnosed using ANY OF the following criteria:[5]

TEST	VALUE
Fasting Blood Glucose	≥126 mg/dL on two separate occasions
2-Hour Post-Glucose Challenge	≥200 mg/dL on two separate occasions
Random Glucose Test	>200 mg/dL with symptoms of uncontrolled diabetes
A1C	≥6.5%

MEDICARE BENEFIT OVERVIEW[3]

Medicare Part B covers diabetes outpatient self-management services only if the physician or qualified non-physician practitioner (the "certified provider") who is managing the beneficiary's diabetes certifies that such services are needed by sending an **original referral form to the diabetes education program.**

The order must be part of a comprehensive plan of care and describe the training that the provider is ordering and/or any special concerns such as the need for general training or insulin-dependence.

Outpatient diabetes self-management training is classified as initial or follow-up training. The following summarizes billable coverage for DSME/T for Medicare Part B:

INITIAL TRAINING	FOLLOW-UP TRAINING
When a beneficiary has not yet received initial training (no history of billed DSME/T). • Eligible to receive **10 hours** of initial DSME/T training within a continuous 12-month period (does not need to be on calendar-year basis). • The 10 hours of initial training may be provided in any combination of half-hour increments, and less than 10 hours of initial training may be used in the 12-month period. • **Nine hours** of the initial training must be in a group setting consisting of 2-20 individuals (not required to all be Medicare beneficiaries). • **One hour** of initial training must be provided on an individual basis for the purpose of conducting an individual assessment and providing specialized training.	When a **beneficiary has completed and been billed for initial 10 hours of DSME/T.** • Medicare allows **two hours** of follow-up training per year (starting with the calendar year following the year in which initial training was completed). • The two hours of follow-up training may be given in any combination of half-hour increments on either an individual or group basis. ***Note – a new written referral is needed annually for any follow-up training to be covered and/or reimbursed.**

Exceptions

- **Federally Qualified Health Centers (FQHC) must provide all DSME/T services in a 1:1, individual format.**
- **Although the Medicare structure states nine hours of group DSME/T and one hour of individual, most programs in Utah are successful in creating their own schedules to fit the needs of their patients.**

UTAH MEDICAID

DSME/T is available to all Utah Medicaid members who have diabetes, such as Traditional Medicaid clients, Non-Traditional Medicaid clients, and Primary Care Network (PCN) clients. Guidelines for billing and referring are the same as implemented for Medicare. Additionally, the same allowances for DSME/T training coverage applies for initial and follow-up training hours. At the time of accreditation from AADE or recognition from ADA, the DSME/T provider must notify Utah Medicaid and provide a copy of the certificate.

For more information, visit: https://www.cms.gov/.

UTAH COMMERCIAL INSURANCE

Most Utah private insurance plans provide DSME/T benefits to their members. Private insurers generally follow the same guidelines for billing and referrals as Medicare. However, please verify patient coverage on an individual basis with private insurers to confirm benefits prior to billing.

REIMBURSEMENT[1]

In order to receive reimbursement for DSME/T through Medicare Part B and Medicaid, the provider must be a Medicare and/or Medicaid provider and have a National Provider Identification (NPI) number, in addition to becoming accredited/recognized through one of the National Accreditation Organization (NAO) locations. Medical entities and healthcare providers eligible for separate payment of outpatient DSME/T include:

- Private provider practices
- Pharmacies
- Hospital outpatient departments
- Outpatient clinics
- Skilled nursing facilities
- Durable medical equipment (DME) suppliers
- Home health agencies
- Federally Qualified Health Centers

In order for a provider to bill for DSME/T, a number of key requirements must be in place:

- Beneficiary must have diagnosis of diabetes.
- A written referral for DSME/T provided by the physician or qualified non-physician provider.
- DSME/T program must have accreditation/recognition from AADE or ADA (the only recognized accrediting organizations by CMS).
- DSME/T program must have a partnership with a Medicare/Medicaid provider that is able to bill the Medicare/Medicaid program.
- Recognition by CMS of the accredited Medicare provider location where the DSME/T will be provided (DSME/T provider must notify CMS of accreditation/recognition from ADA or AADE).

The Medicare reimbursement rates are made under Medicare's Physician Fee Schedule and vary by region. The reimbursement rates and restrictions are updated each calendar year.

Please visit the CMS website for current rates specific to your region https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx.

EXAMPLE OF 2016 UTAH MEDICARE RATE REIMBURSEMENT FOR THE INITIAL YEAR

CODE	DESCRIPTION	BASE REIMBURSEMENT	UNIT	TOTAL REIMBURSEMENT
G0108	DSMT, individual, initial, or follow-up 30 min. increments	$52.14	1 hour	$104.28
G0109	DSMT, group, initial, or follow-up 30 min. increments	$13.99	9 hours	$251.82
			10 hours	$356.10

*Note: Reimbursement rates are based on the Physician Fee Schedule. They may change and may vary in each state. The rates in the table above are meant to be an example. Each provider should check the physician fee schedule in their state, using the link provided above to view the current rates for reimbursement.

DSME/T CODING[1]

Depending on the type of office visit and location in the DSME/T referral process, providers may have use for several Healthcare Common Procedure Coding System (HCPCS) and International Classification of Disease (ICD) codes to bill for screening and counseling. Additionally, billing processes vary across different settings. It is recommended that you discuss the process with the billing personnel for your respective location to understand its structure. The following is a list of commonly used billing codes within the DSME/T process:[8,9]

HCPCS	DESCRIPTION
G0108	DSMT, individual, initial, or follow-up 30 min. increments
G0109	DSMT, group, initial, or follow-up 30 min. increments
ICD-9 CODES	**DESCRIPTION**
250.00	Diabetes mellitus, type II, or unspecified type, without mention of complication, not stated as uncontrolled
250.01	Diabetes mellitus, type I (juvenile type), without mention of complications, not stated as uncontrolled
250.02	Diabetes mellitus, type II, or unspecified type, without mention of complication, uncontrolled
250.03	Diabetes mellitus, type I (juvenile type), without mention of complication, uncontrolled
790.29	Other abnormal glucose
ICD-10 CODES	**DESCRIPTION**
E10	Type I diabetes mellitus
E10.6	Type I diabetes mellitus with other specified complications
E10.9	Type I diabetes mellitus without complications
E11	Type II diabetes mellitus
E11.6	Type II diabetes mellitus with other specified complications
E11.9	Type II diabetes mellitus without complications

MEDICAL NUTRITION THERAPY (MNT)[1]

Medical Nutrition Therapy (MNT) is a complementary service to DSME/T and focuses specifically on nutritional therapy for those beneficiaries diagnosed with diabetes or kidney disease. MNT targets individualized education on nutrition and therapies related to diabetes and kidney disease, where personalized plans are tailored to the needs of the beneficiary.

MNT is **provided by a Registered Dietitian (RD)** and:

- Provides 3 initial hours of therapy in the 12-month period following the initiation of services.
- An additional 2 hours per year of follow-up is allowed after the initial 12-month period.
- Additional hours may be approved if the treating physician or qualified non-physician provider determines there is a medical necessity for continuation of MNT services. **A new referral is required for additional hours of MNT.*
- MNT can be provided in individual or group settings in increments no less than 15 minutes.

Similar to DSME/T, a written referral for MNT is required from the treating physician. Unlike DMSE/T, non-physician providers are not eligible to provide a referral for MNT services.

Because DMSE/T and MNT are complementary services designed to work in conjunction with one another, they can be provided to beneficiaries concurrently. However, it is important to **note that DSME/T and MNT cannot be billed on the same service date.**

COMMON CODES FOR MNT

HCPCS	DESCRIPTION
97802	Individual MNT, Initial
97803	Individual MNT, Follow-Up
97804	Group MNT
G0270	Individual MNT, beyond initial 3 hours or follow-Up 2 hours
G0271	Group MNT, beyond initial 3 hours or follow-Up 2 hours

WHAT'S NEXT

Are you interested in becoming an accredited or recognized Diabetes Self-Management Education provider? There are two accrediting/recognition programs for becoming a DSME/T provider: the American Diabetes Association (ADA) and the American Association of Diabetes Educators (AADE). Both programs meet the 10 guiding principles of the National Standards for Diabetes Self-Management Education (NSDSME), which ensure quality, evidence-based diabetes self-management education.

ACCREDITATION/RECOGNITION LINKS

The following are helpful resources for becoming more familiar with the application process, accessing beneficial tools, and taking the first steps to becoming a DSME/T provider.

Navigate each link below to view step-by-step guidance on helpful checklists, frequently asked questions and examples, to learn about the 10 national standards, access provider resources and educator tools, and detailed information on becoming and accredited/recognized DSME provider.

AADE American Association of Diabetes Educators

American Association of Diabetes Educators (AADE)
https://www.diabeteseducator.org/practice/diabetes-education- accreditation-program-(deap)/applying-for-accreditation

American Diabetes Association.

American Diabetes Association (ADA)
http://professional.diabetes.org/diabetes-education%20

SCHOLARSHIP OPPORTUNITIES

The Utah Department of Health awards scholarships to providers wishing to become an accredited/recognized DSME/T program provider. The one-time scholarship covers all initial application costs to become accredited/recognized through AADE or ADA. It is the responsibility of the provider to prepare required materials and complete the application process. For more information on receiving a scholarship from the Utah Department of Health, please contact diabeteseducation@utah.gov.

CONTINUING EDUCATION OPPORTUNITIES

DSME instructors are required to obtain 15 continuing education credit hours annually in order to maintain accreditation/recognition as a program. The Utah Department of Health provides a FREE Diabetes Webinar Series, which provides 11 of the 15 continuing education credits required annually. The webinar provides CEUs for Registered Nurses, Registered Dietitians, Pharmacists, CHES providers, and more on a monthly basis at no cost. For more information on the webinars and to sign up to receive registration information, please visit http://choosehealth.utah.gov/healthcare/continuing-education/diabetes-webinar-series.php.

NATIONAL DIABETES PREVENTION PROGRAM (NDPP)[10]

The National Diabetes Prevention Program (NDPP) is an evidence-based lifestyle change program with the goal to prevent or delay the development of type 2 diabetes and heart disease among at risk Utahns.

The National Diabetes Prevention Program will become a covered benefit through Medicare in 2018. Similar to DSME, the Medicare Diabetes Prevention Program (MDPP) will be a billable service for Medicare beneficiaries, allowing DPP providers to receive reimbursement for services. For more information on the final CMS bill for the MDPP or to learn how to become a DPP provider, please visit https://www.diabeteseducator.org/prevention.

Program Benefits

- Can help people cut their risk of developing type 2 diabetes in half.
- NDPP research has shown that modest behavior changes helped participants lose 5 percent to 7 percent of their body weight (10-14 lbs. for a 200 lb. person).
- These lifestyle changes reduced the risk of developing type 2 diabetes by 58 percent of people with prediabetes.
- Participants work with a lifestyle coach in a group setting to receive a 1-year lifestyle change program that includes 16 core sessions (usually 1 per week) and 6 post-core sessions (1 per month).

Eligible Participants

The targets for this program are adults 18 and older who are at high risk for developing type 2 diabetes based on fasting glucose or A1C or via a short risk survey.

National DPP Features

- Trained lifestyle coach
- Centers for Disease Control and Prevention (CDC) approved curriculum
- Group support
- 16 weekly meetings
- 6 monthly follow-up meetings

National Diabetes Prevention Program Resources for Professionals

- The CDC's National Diabetes Prevention Program (NDPP)
- Utah Department of Health Healthy Living through Environment, Policy & Improved Clinical Care Program – NDPP website

COMMUNITY HEALTH WORKERS (CHW)[11]

A community health worker (CHW) is a frontline public health worker who is a trusted member of and/or has a close understanding of the community they serve.

This trusting relationship enables the CHW to serve as a liaison between health/social services and community members to facilitate access to services and improve the quality and cultural competence of services provided. A CHW is not necessarily a clinical professional, but receives training to increase health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

Other names for CHWs:

- Community Based Doula
- Community Connector
- Community Health Advocate
- Community Outreach Worker
- Family Health Advocate
- HIV Peer Counselor
- Lay Health Advisor
- Maternal Child Health Worker
- Parent Support Partner
- Patient Advocate
- Patient Educator
- Patient Health Navigator
- Peer Support Specialist
- Peer Educator
- Promotore(a)
- Recovery Coach
- Wellness Coach

How can Community Health Workers impact your DSME/T Program efforts?

CHWs have the potential to address many challenges that healthcare organizations and vulnerable communities share, including but not limited to:

- Initiate DSME patient referral (act as a referral partner for DSME programs).
- Navigate patients from the hospital setting to accessible preventive and primary care.
- Reach beyond the clinic walls to address root causes of poorly controlled chronic disease.
- Gain patients' trust and improve their experience of care.
- Strengthen social capital and build capacity within communities.
- Assist in the management and efficiency of the DSME/T program.
- Teach a variety of DSME/T topics and provide follow-up education to patients on self-management behaviors and skills.
- Perform important non-clinical tasks more cost-effectively than expensive clinically-trained personnel.

For additional information on CHWs and incorporating these individuals into your DSME/T program, visit http://choosehealth.utah.gov/healthcare/term-based-care/community-health-workers.php or email diabeteseducation@utah.gov for more information.

LIFESTYLE CHANGE PROGRAMS FACT SHEET

	CDSMP	DSMP	DSME/T	NATIONAL DPP	STEPPING ON
Title	**Chronic Disease Self-Management Program**	**Diabetes Self-Management Program**	**Diabetes Self-Management Education**	**National Diabetes Prevention Program**	**Stepping On**
Other Title(s)	Living Well with Chronic Condisions Tomando Control de Su Salud (Spanish CDSMP)	Living Well with Diabetes Manejo Personal de la Diabetes (Spanish DSMP)	DSMT (Training)	National DDP CDC approved lifestyle change program (LCP)	
To Qualify	18 years and older with a chronic condition or living with someone with a chronic condition	18 years and older with Diabetes, prediabetes or living with someone with Diabetes or prediabetes	Type 1, Type 2, or Gestational diabetes	18 years and older and have a body mass index (BMI) ≥24 kg/m^2 (≥22 kg/m^2, if Asian)	60+ years, resides in community, cognitively intact, and has had a fall in the past year or is fearful of falling
Physician Referral	No	No	Yes Include specific indicators; type of diabetes, treatment plan, and reason for referral	Yes	No
Reimbursed by	Possible under Medicare Part B, but not currently done in Utah	Possible under Medicare Part B, but not currently done in Utah	Medicare Utah Medicaid Utah health plans	Not covered by insurance	Not covered by insurance
Cost for participant	Free	Free	Medicare 20% copay Medicaid $0–3 copay Private call your insurance	Cost varies	Free
Class Details	Group of up to 15 people; Standardized lesson plan	Group of up to 15 people; Standardized lesson plan	Group and/or individual; Variable lesson plans based upon core curriculum	Group of up to 12 people; CDC approved curriculum	Group of 8–15 people
Hours per series	6 week course, 2.5 hours per class	6 week course, 2.5 hours per class	Up to 10 hours in the first year with 2 hours follow-up per year. Individual and group training	1-year long program; First 6-months: 16 weeks, 1-hour sessions; Second 6-months: 1-hour sessions each month for 6-months	7 weeks, 2 hours/class
Taught by	Trained lay leaders	Trained lay leaders	RN, RD, RPharm or other diabetes educator (CDE)	Trained Lifestyle Coach	2 trained leaders
Accrediting agency	Stanford University	Stanford University	American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE)	CDC	Wisconsin Institute for Healthy Aging
Locations	25 contracted partners (LHDs, AAAs, Health Systems)	Contracted partners (LHDs, AAAs, other partners)	38 sites associated with hospitals and clinics	University of Utah and Salt Lake Community College	14 contracted partners (LHDs, AAAs, Intermountain)
Languages	English, Spanish, Navajo, Tongan and Samoan	English & Spanish	English & Spanish	English & Spanish	English

Find a course now: www.Livingwell.Utah.gov

HELPFUL RESOURCES

Utah Department of Health EPICC Program
www.choosehealth.utah.gov

Utah Living Well Programs
www.livingwell.utah.gov

Current DSME Programs in Utah
http://choosehealth.utah.gov/documents/pdfs/factsheets/factSheet_DSME.pdf
http://choosehealth.utah.gov/your-health/lifestyle-change/dsme.php

For more information on information within this toolkit, please email your request to diabeteseducation@utah.gov

Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

Patient Information

Patient's Last Name _____ First Name _____ Middle _____

Date of Birth ____/____/____ Gender: ☐ Male ☐ Female

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Other Phone _____ E-mail address _____

Diabetes self-management education and training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

Diabetes Self-Management Education/Training (DSME/T)

Check type of training services and number of hours requested

☐ Initial group DSME/T: ☐ 10 hours or ____no. hrs. requested

☐ Follow-up DSME/T: ☐ 2 hours or ____no. hrs. requested

☐ Telehealth

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply:

☐ Vision ☐ Hearing ☐ Physical

☐ Cognitive Impairment ☐ Language Limitations

☐ Additional training ☐ additional hrs requested _____

☐ Telehealth Other _____

DSME/T Content

☐ Monitoring diabetes ☐ Diabetes as disease process

☐ Psychological adjustment ☐ Physical activity

☐ Nutritional management ☐ Goal setting, problem solving

☐ Medications ☐ Prevent, detect and treat acute complications

☐ Preconception/pregnancy management or GDM

☐ Prevent, detect and treat chronic complications

Medicare coverage: 10 hrs initial DSMT in 12 month period from the date of first class or visit

DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

☐ Type 1 ☐ Type 2

☐ Gestational Diagnosis code _____

Complications/Comorbidities

Check all that apply:

☐ Hypertension ☐ Dyslipidemia ☐ Stroke

☐ Neuropathy ☐ PVD

☐ Kidney disease ☐ Retinopathy ☐ CHD

☐ Non-healing wound ☐ Pregnancy ☐ Obesity

☐ Mental/affective disorder Other _____

Medical Nutrition Therapy (MNT)

Check the type of MNT and/or number of additional hours requested

☐ Initial MNT ☐ 3 hours or ____no. hrs. requested

☐ Annual follow-up MNT ☐ 2 hours or ____no. hrs. requested

☐ Telehealth ☐ Additional MNT services in the same calendar year, per RD

Additional hrs. requested _____

Please specify change in medical condition, treatment and/or diagnosis:

_____

_____

_____

_____

_____

Medicare coverage: 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

Definition of Diabetes (Medicare)

Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:

- a fasting blood sugar greater than or equal to 126 mg/dl on two different occasions;
- a 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions; or
- a random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes.

Source: Volume 68, #216, November 7, 2003, page 63261/Federal Register.

Other payors may have other coverage requirements.

Signature and NPI # _____ Date ____/____/____

Group/practice name, address and phone: _____

Revised 8/2011 by the American Association of Diabetes Educators and the Academy of Nutrition and Dietetics.

Resources

1. Funnel M, Brown T, Childs B, et al. National standards for diabetes self-management education. Diabetes Care. 2008;31(1):S97-S104.
2. National Diabetes Statistics Report. U.S. Centers for Disease Control and Prevention website. https://www.cdc.gov/diabetes/data/statistics/statistics-report.html
3. Diabetes self-management education resource. National Association of Chronic Disease Directors website. http://www.chronicdisease.org/?page=DiabetesDSMEresource#Reimbursement
4. Joint position statement toolkit. American Association of Diabetes Educators website. https://www.diabeteseducator.org/practice/educator-tools/joint-position-statement-toolkit
5. The importance of follow-up. American Association of Diabetes Educators website. https://www.diabeteseducator.org/practice/provider-resources/importance-of-follow-up
6. Working with a diabetes educator. American Association of Diabetes Educators website. https://www.diabeteseducator. org/practice/provider-resources/working-with-a-diabetes-educator
7. AADE7 self-care behaviors. American Association of Diabetes Educators website. https://www.diabeteseducator.org/patient-resources/aade7-self-care-behaviors
8. Standards of medical care in diabetes – 2015. Diabetes Care. 2015;38(1):S1-S93.
9. New ICD-1-CM codes for diabetes self-management training. American Association of Diabetes Educators website. https://www.diabeteseducator.org/docs/default-source/practice/deap/faq/new-icd-10-codes.pdf?sfvrsn=0
10. National diabetes prevention program. Utah Department of Health Healthy Living Through Environment, Policy, and Improved Clinical Care Program website. http://choosehealth.utah.gov/your-health/lifestyle-change/diabetes-prevention-program.php
11. Community health workers. Healthy Living Through Environment, Policy, and Improved Clinical Care Program website. http://choosehealth.utah.gov/healthcare/term-based-care/community-health-workers.php
12. Evidence-based lifestyle change programs fact sheet. Utah Department of Health Healthy Living Through Environment, Policy, and Improved Clinical Care Program website. http://choosehealth.utah.gov/documents/pdfs/factsheets/factSheet_EBLCPs.pdf

UTAH DEPARTMENT OF
HEALTH

Healthy Living Through Environment
Policy and Improved Clinical Care (EPICC)

choosehealth.utah.gov